

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6805 = 62-028715  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED JUL 31 1962**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. Louis Mo</b>                 |  | c. CITY OR TOWN <b>Saint Louis</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>8814a Riverview Blvd.</b>   |  |

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 3. NAME OF DECEASED<br>(Type or print)   |                                  | 4. DATE OF DEATH  |  |
| <b>Bessie</b>  |                                  | <b>July 9 1962</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/19/89</b>                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Saleswoman</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Unknown</b> |
| 13a. FATHER'S NAME<br><b>Unknown</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |                                  | 17. INFORMANT<br><b>Mr. E.J. Bridge, 4325 N. Grande Blvd. 7</b>   |  |

|  |  |
|--|--|
| 14. NAME OF HUSBAND OR WIFE<br><b>Late Claude Hargrave</b> |  |
| 16. SOCIAL SECURITY NO. _____                              |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>                         |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>   |
| DUE TO (b) <b>Cerebral arteriosclerosis</b>  |  |   |
| DUE TO (c) <b>332X</b>   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Bronchopneumonia</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|---|---|--|

|   |                  |
|---|------------------|
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m. | Month, Day, Year |
|---|------------------|

|  |  |                              |        |       |
|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

|   |  |
|---|--|
| 21. I attended the deceased from <b>May 3 57</b> to <b>July 9 62</b> and last saw her alive on <b>July 8 62</b>     |  |
| Death occurred at <b>1:40 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |

|  |   |                                   |
|--|---|-----------------------------------|
| 22a. SIGNATURE<br><b>H. H. Slesener MD</b> | 22b. ADDRESS<br><b>206 Northland Med.</b> | 22c. DATE SIGNED<br><b>7-9-62</b> |
|--|---|-----------------------------------|

|   |                                   |   |   |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>July 11, 1962</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b> | 23d. LOCATION (City, town, or county)<br><b>St. Louis County Missouri</b> |
|---|-----------------------------------|---|---|

|   |  |   |
|---|--|---|
| 24. FUNERAL DIRECTOR<br><b>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 10 1962</b> | 26. REGISTRAR'S SIGNATURE<br><b>Roan Smith M.D.</b> |
|---|--|---|

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59.

1

2 **209**

3 **12**

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11

12 **740**

13

**74**

DR. H.H. Stesener  
Northland Med. Ctr.  
EV 3-0127

Hours  
Mon. 11-12 1-5  
Tues. 11-12 1-5

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert E. Mullen

Licensed Embalmer No. 4916

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.